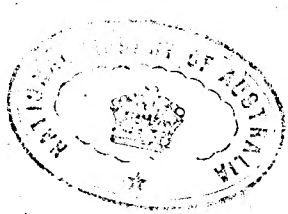
PSYCHIATRIC CASUALTIES

Hints to Medical Officers in the Army of the Middle East

GENERAL HEADQUARTERS
MIDDLE EAST
CAIRO

MARCH, 1941



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Psychiatric casualties among soldiers comprise (a) cases which are frankly mental, (b) reactions of various types normally described as "nerves," and (c) an important group of cases with bodily symptoms whose origin is purely psychological. Among the members of group (a) special mention must be made of congenital mental defectives whose real condition is frequently overlooked.

In an Army in the Field it is important that psychiatric casualties are diagnosed and dealt with as early as possible. Some of the conditions are "contagious" and, being liable to spread in a unit, may cause serious loss of efficiency. Others render the sufferers dangerous, and none more so than the soldier, who is armed and has the means at hand to inflict damage on himself or on other people.

There is no mystery about the treatment of psychiatric casualties; it is based on common sense and on a sound knowledge of medicine; and it is encouraging to record that many of these casualties are more easily and successfully treated than their counterparts in civilian practice, especially if treatment is applied at an early stage.

Classification of Psychiatric Casualties

For practical purposes we may regard these casualties as divisible into two main groups:—

A. Psychotic casualties, i.e., those which in every-day practice and language would be regarded as "mental." and

B. Neurotic casualties, i.e., those comprising all the the different varieties of neurosis of which hysteria, neurasthenia and anxiety states may be cited as common examples.

Briefly these two groups may be described as "P" and "N" casualties.

A. *Psychotic Casualties.*—The major mental disorders in no way differ from those seen in civilian practice.

Mental Deficiency* as seen in the Army is usually of the grade known as feeblemindedness, dull backward men almost incapable of learning. It is remarkable how many of such men succeed in gaining admission to the Army and how long they remain undetected. Such soldiers are anxious to conceal their true condition from fear of being discharged. Under the stress of active service conditions they eventually break down, frequently appearing to be neurotic or even psychotic as they readily imitate the symptoms of other cases with which they have come into contact.

An Army is mostly composed of young men and therefore the psychoses (mental illnesses) most likely to be encountered are those seen in the third and fourth decades of life. In this age period the most frequent psychotic breakdown is due to schizophrenia (dementia praecox), or to one of the phases of the maniac depressive psychosis, excitement or depression. Depression is usually obvious, but mild states of excitement are easily missed as the patient presents a superficial appearance of enjoying abounding health and energy.

Among older men there is a depressive state occurring at the involutional period of life (roughly 45 to 55). This is signalised by complaints of insomnia, loss of confidence, anxiety, loss of emotional control, and sometimes by ideas of guilt or of unworthiness. It may be accompanied by evidence of arteriosclerosis.

There are the mental states due to poisons and infections. Some, for example, result from the excessive consumption of alcoholic drinks, especially those of high toxic potentiality such as zibib, araqi or synthetic spirits. The effect of drinks "laced" with native products can be an acute state of intoxication accompanied by confusion and hallucinations and by senseless behaviour which may get the soldier into serious trouble. Addiction to drugs should not be overlooked; they are easily obtained in the Middle East, and periodic mental confusion should always suggest the possibility of drug taking. Among the infections, cerebral malaria must never be forgotten in the Army, and in this connection it should be noted that acute mental symptoms may be produced by the administration of atebrin.

The typical mental symptoms of any toxic state, including that of all the common acute infections, are confusion and restlessness, with loss of appreciation of relationships in time and space and of the identities of persons about the patient. Illusions and hallucinations may also occur. A state of con-

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* For convenience, cases of congenital mental defect are included here among psychotic casualties.

fusion without the extreme restlessness of delirium may result from the exhaustion following acute infections and long debilitating illness.

Profound mental confusion can also result from vitamin deficiency. Pellagra is a good example of a vitamin deficiency (Nicotinic Acid) which may present itself as a mental rather than as a physical illness.

B. *Neurotic Casualties.*—These are the minor mental disorders usually designated as "nerves," and again show no real difference from those met in civilian practice. In war many of them are so dramatic in their onset and in their symptoms that medical officers are inclined at first to think of them as something clinically new. They consist of anxiety states, hysterical manifestations, neurasthenia, obsessions and compulsions and a group somewhat unsatisfactorily labelled "psychopathic personality." It is a convenient label, however, and can be made to include cases that do not seem to fall readily into any descriptive group. Such men may be regarded as never fitting into any position into which they are placed. Irresponsible, they may claim all sorts of skill they do not possess: they have no sense of realities, are careless about orders, and are generally undisciplined. Conduct is often peculiar, and without regard to consequences. Frequently quite intelligent, they can seldom find work at which they will persevere. It is not unreasonable to describe this condition in the vulgar but well understood phrase — "bloody minded." Such men are probably defective in development; happily, they are rare.

It is easy to think of the minor mental disorders as occurring in two main groups:—

I. Battle Neurotics (resulting from action).

II. Neurotic Sick.

I. Battle incidents may precipitate a sudden onset of acute symptoms. Common examples of such incidents are severe bombing from the air, close bursts of shell or bomb, harrowing or unpleasant sights, or being buried in the debris of shelters or buildings. The symptoms produced may vary from a shivering stuporous state to hysterical manifestations like deaf mutism, a paraplegia, or blindness. It is these patients that provide the dramatic element in war neuroses.

II. Neurotic sick are much less obvious and consist of patients whose symptoms are suggestive of physical illness, and who complain of indigestion, palpitation, headache, pains in the chest, etc. Investigations reveal no "organic" explanation of the symptoms, but it will nearly always be found on enquiry that such cases have many "nervous" accompaniments of their illness, such as loss of sleep, dreams of the nightmare variety, and fears of many kinds.

The Causes of Breakdown

Factors producing breakdown may be divided into three, each beginning with a "P" — Physical, Psychological, and Parental. Parental is here used for the sake of alliteration and means more than just the material of which an individual is made. It is intended to embrace the whole family history, the patient's nurture and unbringing, and what is vaguely described as his constitution; in fact, his whole life story. These three "Ps" are nearly always involved in each case, though one may be more in evidence than the others.

For example, a man receives distressing news from home (Psychological). This worries him, he loses sleep and appetite and subsequently weight (Physical). So conditioned the man goes into battle, which he may have done before. But this time a shell-burst nearby turns him into a tremulous wreck, stuporous or confused, maybe blinded, deaf and dumb, or paralysed in one or more limbs. Although untouched, he has developed symptoms and has become a "battle neurotic." On careful enquiry in hospital it is found that one parent is highly strung and that his parents separated during his childhood (Parental factor). Take another example: an officer, now 53 years of age, complains of insomnia, depression, failure of concentration and memory. Investigation shows an enlarged heart, high blood pressures and a degree of arterio-sclerosis (Physical). Enquiry reveals a familial tendency to neurological lesions (Parental). Further investigation shows that he has recently had a promotion and that he has worked hard but always with the fear that his new position is beyond his powers (Psychological).

General Causes of Stress.—In this Army of the Middle East certain *general* conditions associated with service may be regarded as severe enough to pave the way for breakdown in certain individuals; examples are heat, flies, sand, the inevitable curtailment of personal liberty, the impossibility of home leave and lack of sexual outlet. Personal relationships are sometimes the source of much difficulty, friction, and neurotic sickness. Among large numbers of men living and working in close association personal dislikes or resentments, even occasional animosities, are almost inevitable.

Special Causes of Stress.—First among these come the conditions of battle. Hostile fire, noise, bombing and shelling—particularly explosions near at hand with their blast effects—the sight of the dead or of specially unpleasant wounds, all these act as precipitating casual factors in both officers and men. Accompanying them are factors of a physical kind, irregular meals, shortage of water and of sleep, uncleanliness, and physical exertion to the point of exhaustion. Exhaustion plays a considerable part in many cases, and some men will

recover with dramatic suddenness after adequate rest and sleep. Other special psychological stresses are domestic bereavements, especially when due to enemy action, financial hardship and the infrequency and irregularity of news from home.

Tropical infections and debilitating illnesses like dysentery undoubtedly act as special stresses by reducing the patient's physical and mental reserves. Lastly, certain other organic conditions and habits should be mentioned. Among older men, definite mental changes should always cause medical officers to look for evidence of arterio-sclerosis, and consider the possibility of paresis or cerebral tumour. Alcoholic consumption varies widely with different individuals; what requires to be appreciated is the fact that excessive consumption is often a symptom rather than a disease itself. Any sudden rise in the use of alcohol (or tobacco) should raise the suspicion of underlying neurosis.

These notes do not intend to suggest that psychotic or neurotic breakdown need result from any or all of the conditions mentioned. Men predisposed to psychosis (insanity) will suffer breakdown under any stress, or with none. Neurotic illness is different. It is more purposive and in many — though not in all — is fundamentally an escape mechanism.

Neurotic Thought and Action.—It may help medical officers to dwell for a little on the differences between rational and neurotic thought and behaviour. An example or two may make them clear. Service in this Army is admittedly carried out in a hot climate. It would seem obvious that a higher standard of physical fitness is required than is necessary for service in a temperate climate, and the normal individual attempts to maintain or acquire that standard. The neurotic focusses his thought on the difficulties of the climate, especially the hot sun, avoids effort and the need to reach the standard of fitness required, doses himself with beer, and goes sick when called on for exertion. So with bad news or no news from home, which is certainly trying for all. The normal individual reacts to it by appreciating that he can do nothing personally. But he can and does write or cable to friends or relations in a position to help. The neurotic reaction in thought is to assume that the worst that can happen has happened; reaction in conduct avoids doing what is possible and seeks escape and relief from the whole situation by a senseless debauch or the development of symptoms.

In the presence of danger fear is a normal emotional state.

The whole object of military training is to ensure that conduct in danger is rational and ordered, not irrational and neurotic. Fear that ends in flight properly ends in a court

martial. But fear that ends in symptoms is not altogether free from the suspicion that men are enabled to escape further trial with medical approval. Medical officers should guard against this possibility by insisting on all nervous casualties being brought to them under proper authority, by taking care not to evacuate such cases too readily, and by themselves paying no heed to rumours that may become prominent among unseasoned troops in action.

Early Signs and Symptoms

(a) Of Psychosis.—Major mental illness is almost invariably accompanied by insomnia and by loss of weight and appetite. The mental condition will vary. States due to organic change usually show a marked failure of memory and a general intellectual deterioration demonstrated by quite simple tests of addition and subtraction, and by simple performance problems like doing three easy tasks in a certain order. The mood may be one of depression, of excitement, of apathy or of indifference. Retardation will be seen with depressed patients as a slowing of thought and action; a "flight" of ideas and "press" of activity with excited patients. The presence of delusions is not always easy to elicit: these may be ideas of guilt or unworthiness, strange notions of bodily illness, a feeling by the patient that people are talking about him, or influencing his thoughts from a distance. Hallucinations, which are sensory experiences in the absence of stimuli, also occur in certain mental states. They are quite common in delirium for example. A change in character and behaviour strongly suggests a mental cause. Some cases will provide a history of former attacks, and positive familial histories are frequently obtainable.

Nothing more need be said of psychotics. Having decided on the presence of major mental symptoms, the patient is evacuated, accompanied by as *full a history as possible.* It is important to bear in mind that all depressed patients are potentially suicidal.

(b) Of Neurotic Casualties.—Early signs of neurosis again often comprise changes in habitual behaviour. The cheerful comrade becomes morose, irritable, and seclusive. The consumption of alcohol and tobacco may be increased. The patient may get into disciplinary trouble for careless work or slovenly appearance. Of symptoms, the patient may complain of fatigue, of loss of concentration, of loss of emotional control, such as a desire to weep for no apparent reason. Some complain of loss of sleep, but although insomnia is frequent, it is remarkable how few neurotics make it a cause for complaint. Some patients will visit the medical officer and complain of "nerves," which makes it easier to have a frank talk, and take a careful history.

Medical officers to units should encourage executive officers to consult with them over men showing such changes. Experience of full discussion with cases of this type will show that simple measures are often all that is necessary. The care of sleep, a letter or a cable home, a move to another platoon, discussion of fear, of war dreams or battle incidents of a gruesome kind, domestic anxieties, sexual experience or perversion, fears of insanity, such are the preoccupations of many men in the early stages of a neurosis. But it is not always so simple. Many cases do not complain at all of their "nerves." Their only complaint may be of a physical kind, and the men tend to be constant attenders at sick parades. The usual symptoms are indigestion, headaches, palpitation, "boiling" feelings in the epigastrium, tremors, frequency of micturition, Diarrhoea, breathlessness, pain the chest, giddiness. When no evidence of organic disease can be found, these and similar symptoms are almost certainly due to emotional causes.

Treatment of these "neurotic sick" is often disappointing. It is important to make sure in one or at the most two complete examinations that the condition is not organic. The patient, who has almost certainly been thinking of his symptoms in frightened terms, can then be reassured firmly that there is no heart disease, or the cancer which he may have dreaded. No further physical examinations should be made or the patient will feel that the medical officer is not in fact confident of his own diagnosis.

If time and circumstances allow, M.O's. are advised to take a very full history. Begin by asking the patient to describe in detail the circumstances under which he first noticed the symptoms, and work backwards into his life story. In doing this the sources of conflict and emotional disharmony gradually become exposed. Once tried, this work becomes of great interest and will produce surprising results. Never forget to ensure sleep.

Battle Neurosis.—These cases are the most difficult and dramatic of the neuroses met in war. Difficult because the question of diagnosis may provide many puzzles. Their dramatic nature, as has been said, may lead an inexperienced medical officer to feel that he has encountered a new disease. Clinical manifestations are kaleidoscopic — there may be a species of panic reaction, with screaming, rushing aimlessly about, sometimes a senseless aggressiveness against friends or comrades. There may be shouting of repetitive sentences, crying, hysterical fits; there may be fainting, unconsciousness in the form of stupor or coma, or a staring cataleptic state which resembles closely the catatonic stupor seen in dementia praecox. Gross tremors frequently accompany the stuporous conditions, with jactitating convulsive movements of the body in response

to any noise. Another group of cases shows less anxiety, but produces functional disabilities of a dramatic nature, such as deaf mutism, blindness, paralysis in one or more limbs, or loss of memory. Diagnosis is difficult when an unconscious patient is brought in with a history of having been "blown up" by a shell or bomb explosion. Is he suffering from intracranial injury? Is he a case of hysterical stupor? The answer to these questions can often be found by rapid neurological examination. Is the skull intact? Are conjunctival and corneal reflexes present? Are the pupils equal, small or dilated — are the tendon reflexes (knee jerks, etc.) present? Are they equal on the two sides? Is there any attempt at response to shouted question? Does the depth of unconsciousness lessen or increase? In general it may be said that the presence of neurological signs points to severe concussion or intracranial injury such as laceration of the brain, or haemorrhage. A progressive deepening of the coma is strong evidence of intracranial damage. In the absence of neurological signs the patient is probably lightly concussed or "functional." Any doubtful case of this type should be evacuated speedily as a stretcher case.

"Battle" neurotics do not necessarily break down while in action. Some cases will get through an engagement or half a war satisfactorily and then develop symptoms. The breakdown may be quite sudden, precipitated by some trivial incident like an unexpected fall or a back-fire in passing motor traffic, or it may be gradual. In the latter case the soldier suffers from steadily increasing symptoms. Tremors, sweating, palpitation, fretting over unpleasant battle scenes, disturbed sleep, recurrent and vivid dreams or nightmares from which he may awake shouting or struggling. Such men are apt to get teased or bullied by their comrades. They show disorders of conduct, brooding and solitariness, irritability and a definite change in character. This is the type of case company officers should know about and medical officers can help such men materially.

Clinical Types

Acute anxiety cases, panic and terror reactions and conversion hysterias have already been described briefly and attention has been drawn to the frequency of neurotic symptoms among the sick. There are several other types of neuroses which may be encountered. The commonest is perhaps what may be called *neurasthenia,* or its near relation, *"reactive depression."*

Both occur in men subjected to monotonous conditions without much change or relief. A couple of years spent in desert warfare for example, or the gruelling routine of ships at sea. The clinical features are: fatiguability, both physical and mental, headache, usually described as a "cap" of pressure at

its worst in the mornings, and emotional depression. The patient is a caricature of the state of mind commonly described as "fed up." He is often constipated, with low systolic blood pressure, and he may complain of indigestion and loss of appetite. As a consequence of the rapid onset of mental fatigue he complains of inability to concentrate, of failure of memory and a general loss of interest in work or play. When the emotional depression is severe, these men will often say they would "be better out of it," and do occasionally commit suicide. Cases vary in severity; environmental and emotional factors play a large part in their causation. Bereavement, domestic troubles, unhappy love affairs, unsatisfactory relationships in his unit, may produce marked "reactive depression" states in a soldier. The factors of toxaemia, injury, and especially exhaustion are also important. Neurasthenic states are seen in patients after toxic illnesses of a debilitating kind, and are common after head injuries. Reactive depression (as its name suggests) is the response to exogenous causes which can often be remedied. The true neurasthenic's condition is more endogenous in origin and is much less easy to treat successfully. Cases will be seen in which a species of nervous exhaustion is produced by hot climates, and when men are subjected to long terms of active service in tropical climates, the neurasthenic reaction may be expected to occur in increasing numbers.

Hysteria.—Hysterical manifestations of acute onset in battle conditions have already been mentioned. Amnesia (loss of memory) is common, and the usual story is that the soldier remembers a flash and explosion, or witnessing some incident of battle, and then remembers nothing more.

Hysterical amnesia differs from the amnesia resulting from concussion in several respects. First it is not of a retrograde type. The patient concussed say, at tea time, will commence his amnesia at breakfast time on the same day, or even further back. The hysterical amnesic remembers clearly up to the precipitating incident and there is no retrograde amnesia. The amnesia of concussion is complete, whereas the amnesic period in hysteria tends to be patchy. Further, the hysterical amnesia is easy to restore in contrast to the traumatic amnesia.

Loss of memory introduces another hysterical phenomenon of considerable importance from the point of view of military law — the *hysterical fugue.* This condition is due to a sudden dissociation, and is allied to loss of memory and to double personality. A soldier is found wandering, possibly miles from his unit. He can give no account of himself, does not know his name or his unit, and can give no reason for his presence in that particular area. Such wanderings (fugues) may last for days, during which time the soldier will not as a rule attract any attention to himself by eccentricities of conduct.

When the fugue comes to an end the patient "wakes" and wonders where he is and what he is doing. He will have little or no memory of what he has done during his fugue. Supposing such a man to have wandered away from his unit while in action, the medico-legal question of responsibility will arise. The hysterical fugue is a clinical condition to which some people are liable, and can be compared with post epileptic automatism. Most authorities would agree that a soldier cannot be held responsible for the occurrence of dissociation (the onset of the fugue) or for his actions during the period of wandering. Each case must be considered on its merits and expert opinion sought in case of difficulties. If such fugues repeat themselves on return to duty disciplinary action should be considered.

Before leaving the subject of hysteria another group of cases requires mention. It may be summarised by the phrase hospital hysteria. In this group, hysterical additions are made to injuries, additions such as extensive anaesthesia, contractures of various kinds and sometimes paralyses. Great care is necessary in eliminating organic disease. Some cases of paralysis accepted too lightly as "functional" will prove later to be of organic origin. Another result of injury, especially orthopaedic injuries, is an hysterical gait, and the same care in diagnosis is advisable. After an acute attack of anxiety neurosis, the anxiety symptoms may subside and be replaced or possibly accompanied by more frankly hysterical manifestations, such as a stammer, or weird hysterical gaits or tics.

Anxiety Neurosis.—The acute condition has been described, and the sick parade type mentioned. These cases need not necessarily begin their illness under battle conditions. The anxiety neurosis is a condition presenting mental and physical signs and symptoms for which no organic cause can be found. It is accompanied by morbid anxiety with physical signs similar to those produced by adrenalaemia — widely dilated pupils, tachycardia, pallor. There are all sorts of subjective sensations: choking, pains over the heart, fears of collapse and even of sudden death. It is useful to think of the condition as a vicious psycho-somatic circle which once under way may go on until organic disease may result from the prolonged disturbance of function. An anxiety state appears to be the chief neurosis of present day armies, as it seems to have been of civilian practice in latter years. Anxiety may be described as an emotional state closely allied to fear accompanied by numerous somatic symptoms and aroused especially by situations in which uncertainty and insecurity are prominent. It is obvious that the soldier is often in such positions, particularly when he is untrained or partly trained. A soldier who is not quite sure what he ought to do will so increase his sense of insecurity that a natural fear may become panic. The matter

of training is no concern of the medical officer, but he may wisely point out the close relation between fear, panic, and anxiety states on the one hand, and lack of training with consequent increased sense of insecurity and defencelessness on the other. It is often claimed that an anxiety neurosis is "just funk." This is not quite true. Fear is a natural result in any soldier of situations, such as actions with the enemy, in which the strong instinct of self preservation is threatened. The highly trained soldier has so developed his obedience to his leaders, to ideas of duty, discipline and the "team spirit," that he automatically performs the requirements of the herd, which for him may be the nation, the army, the unit, or even the section of which he is a member. Further, fear can stimulate fight and not flight; emotional states of anger, rage, or milder hostile sentiments serve to strengthen aggression and determination and fear disappears. Anxiety is a more chronic persistent emotional state of fear *plus* bodily effects which may be extremely crippling and which remain when all danger is over. Signs vary from loss of consciousness, to tremors, a racing pulse, loss of ability to rest or sleep, loss of appetite, and such dread about the way the body is behaving that the soldier sooner or later becomes a casualty.

This does not answer the question why some soldiers react in terms of anxiety states. The answer is complex. It is partly dependent upon leadership, and the general emotional state of the unit of which the soldier is a member. But it is also dependent upon physical, psychological and parental factors in the history of the individual soldier. Anxiety is more likely to develop in men whose physical health is poor by reason of recent illness, or chronic infection. There will be psychological reasons at work, conflicts of a nature unrealised by the patient and inaccessible to the observer, while the man may be a member of a family in which "nerves" are prominent, or have passed a childhood with people who in ignorance conditioned him for anxiety in adult life by a foolish upbringing. While there is a "breaking strain" for all of us, in some men it is reached sooner for the general reasons just mentioned.

Obsessional and Compulsive States.—These states are not unknown among quite normal people. Dressing or undressing must be done in a certain order, objects must be placed in certain positions, cracks in the pavement must or must not be stepped on, a tune will repeat itself and cause a vague sense of discomfort if it is not hummed or whistled. Such minor obsessions do not interfere in any way with normal thinking and conduct.

But there are cases of obsessional thinking or compulsive behaviour which absorb the whole waking life of the individual concerned. Examples are the obsessional beliefs and fears of

bodily illness — cancer or syphilis, resulting in the pathetic wanderings from doctor to doctor for advice. Temporary relief is obtained after reassurance, but the obsessional ideas return. Again, a man may concern himself with philosophical thought, and spend his day wondering why the world exists or whether there is a God. There is no end to the subjects of obsessional thinking, and the individual may get so absorbed that he has no time to spare for worldly affairs. These remarks are equally true of compulsive acts. Obsessional states quickly unfit a soldier for duty, treatment is lengthy and frequently unsuccessful, and such soldiers cannot be kept with an Army in the field.

Epilepsy.—In spite of precautions, men suffering from fits get into the Army, or develop fits after enlistment. A few have had "petit mal" or minor epilepsy for years and remained in ignorance of the real nature of the condition. Epileptics should be sent to hospital with a full history. If a major epileptic fit has been actually witnessed by the medical officer he should send with the patient a certificate to that effect, describing the condition, noting wetting, tongue biting, absence of eye reflexes, and any somnolence, excitement or disturbance of conduct *after* the fit. Minor epilepsy or "petit mal" may be so momentary as to escape detection. A change of colour nearly always takes place, together with a brief mental confusion or transitory loss of memory. "Petit mal" may occur without "grand mal" and vice versa.

Epilepsy is specially mentioned in these notes on account of its medico-legal importance. An officer, N.C.O. or man may have his first major fit in the street or other place, and be found unconscious in the post-paroxysmal stage. Not unnaturally he is assumed to be drunk, and a very serious charge may result. Medical officers should always enquire for a history of fits in cases found unconscious. "Petit mal" may be followed by a period of automatism, in which the patient has no knowledge of what he is doing, and during which he may perform all sorts of anti-social acts. It need hardly be said that epilepsy unfits most men for any form of active service — and expert advice should be sought. It is essential to provide good notes of such cases, describing in detail the nature of the attacks.

Self-Inflicted Wounds.—With some reason these may be classed as neurotic manifestations. The medical officer must not overlook such injuries. Doctors tend to think primarily of their patients as individuals requiring help, and are inclined to allow such wounds to pass without taking action. This is a wrong attitude. Military medicine requires medical officers to think first of the welfare of the group rather than of the individual.

Self inflicted wounds are commonly in the left forearm, hand, or foot. But they may occur in other sites that can be got at

by rifle or revolver. The boot, clothing, and skin around the entrance wound may show burning and staining, and may have a characteristic smell. Sometimes it is possible to find in the wound or about the clothing a small cardboard disc which in some ammunition is used as a wad between charge and missile.

Careful notes should be taken of the evidence causing the M.O. to suspect any injury is self-inflicted.

Treatment

Notes on treatment are written in the full knowledge that there may be conditions in which the suggestions made will not be possible for the medical officer in forward areas to carry out. Hints on treatment here deal chiefly with acute neurotic states developing in action, the panic reaction, anxiety and hysterical states, amnesia, etc.

Treatment of Battle Cases (developing in action).—Medical officers should be careful not to treat as casualties unwounded men wandering away from the line on their own responsibility. Each nervous casualty should have written authority for presenting himself to the M.O. or be accompanied by a stretcher bearer. While circumstances must dictate the disposal of nervous casualties, and medical officers be free to exercise individual judgment in each case, rapid evacuation should be avoided whenever possible. There is a tendency for each medical unit to pass on such casualties, without attempting any form of treatment. The following measures will be found to produce good results in the majority of cases, and the earlier they are tried the better.

1. Reassurance, a sweet drink, hot or cold, according to season.
2. A mild purgative pill or draught.
3. A strong hypnotic. The hypnotics of choice are the barbiturates:

   Medinal (10 to 15 grains in solution), Phenobarbitone (3 grains), Nembutal (two or three capsules of 1½ grains each, maximum 4½ grains), sodium amytal (3 grains in capsule), paraldehyde, a safe and quickly acting hypnotic, but unpleasant to take and requiring a vehicle such as milk (three or four drachms in at least six ounces of milk, or other fluid), the bromides, sodium, ammonium or potassium salts (30 grains).

4. Cover with a blanket and allow to sleep, on a bed if available, or a stretcher with a pillow.

   Sleep is thus secured for several hours. On waking many cases will have lost their tremors and other anxiety signs and should be given food, and at least a pint of fluid, well sweetened with sugar or glucose.

The procedure can be repeated with half the original doses of sedative, or the patient can then be evacuated.

The choice of hypnotic will probably be decided by the stores carried by the unit, but there are certain points which should be remembered. Bromides ought not to be repeated frequently, as they produce confusion especially in individuals over 45 years of age. Paraldehyde to certain people is an excitant. Men who are in a state of restless excitement may refuse medicines and may require an injection. The following are useful:—

A subcutaneous injection of hyoscine hydrobromide (gr. 1/75 or 1/100) which may be combined with a morphine salt.

Intramuscular injections: Somnifaine — dose 3-5 c.c. given into the gluteus medius or the extensors of the thigh.

Luminal is also prepared for intramuscular injection and is put up in 1 c.c. ampoules of a 20% solution. The dose is 1 c.c. and care must be taken to see that the syringe used is quite dry.

Hysterical palsies, deaf mutism, etc., can be tackled at once. A confident approach is necessary and it is better, for example, in the case of a paralysed limb to begin with manipulation of the sound limb on the other side. Show the patient that he has full movement on that side and gradually suggest that he performs certain movements with the paralysed limb in company with the sound one. Fifteen to twenty minutes will frequently suffice to remove hysterical symptoms at an early stage.

Never adopt a bullying attitude to hysterical or anxiety patients. One of their fears is that they may be thought to be malingering (which is not a true assessment of the case), therefore once a doctor suggests even by tone of voice that he thinks the symptoms are not genuine, confidence in him will be lost.

These lines of treatment should be attempted by the medical officers of units, by Field Ambulances, or Casualty Clearing Stations.

Neurotic Sick.—This group of cases comprises those soldiers whose complaints are expressed in physical terms for which no organic causes can be found. Their treatment has already been sufficiently discussed, but one syndrome of importance in regard to treatment by specialists must be mentioned.

Effort Syndrome.—This condition is singled out for mention as it is not uncommon among soldiers, and arrangements have been made for its treatment in a special centre.

The main symptoms fall into two groups (a) cardiac and (b) nervous. It is the cardiac symptoms which attract the attention of the soldier, and in his mind constitute his disability. Yet the condition is usually of nervous origin and is not associated with cardiac disease.

The presenting symptoms are palpitation, pain in the precordium, giddiness and breathlessness on slight exertion. These cardiac symptoms are accompanied by apprehension, nervousness and feelings of exhaustion. Most of the subjects present abnormalities of a psychological kind, but previously healthy men may develop similar symptoms under prolonged physical or mental stress.

The syndrome is one which requires care in both diagnosis and treatment. In diagnosis, to exclude organic disease or toxic or endocrine factors; in general management and treatment to avoid the implantation of an obsessional "cardiac neurosis." Arrangements have therefore been made for these cases to be sent to a special centre, where facilities for their assessment and treatment have been provided. Delay in the institution of treatment is highly undesirable, and prejudices the chances of recovery. As these cases are primarily nervous in origin, they are very susceptible to suggestion, particularly if it is in accordance with their own outlook, i.e., if it is "unfavourable" or can be interpreted as such. Medical Officers therefore should be careful to avoid repeated examinations of the praecordium, pulse readings, and exercise tolerance tests. Remarks like "heart strain," "D.A.H.," or "soldier's heart," or reference to "murmurs" or "valve trouble" are also to be avoided. Such procedures and phrases tend to focus the soldier's attention on his heart, and may initiate chronic neurosis. For the same reason prolonged rest in bed is to be avoided.

It is important that these men be received for treatment as soon as possible after the onset of symptoms. All men therefore whose symptoms suggest a diagnosis of "effort syndrome" should be sent without delay to the special Effort Syndrome Centre at the *23rd General Hospital.* In ordinary circumstances such cases are not to be treated elesewhere.

The remarks on *repeated* physical examinations and special investigations like X-Rays, blood counts, etc., apply to all cases of neurotic sick. Such procedures should be reduced to a minimum or the patients will conclude the M.O. takes an unfavourable view of their condition in spite of what he may say.

Anxiety neurotics, if not responding to treatment of the acute symptoms, should be sent to a neuro-psychiatric centre for expert treatment. Many anxiety cases are met with as "neurotic sick," and while psychotherapy of a technical kind will be impossible, it is not impossible to take a full and careful

history. This detailed history may prove to be true psychotherapy and successfully reveal the soldier's difficulties.

Neurasthenia does well with rest and over-feeding. When depression is a marked feature, particularly in the neurasthenic state which is a sequel of illness, benzedrine sulphate tablets (10-20 mgm.) twice daily will often relieve. Care must be taken to give no benzedrine after the midday meal. Once more, enquire always after the state of the sleep. Ensure the soldier good rest when his sleep is short or disturbed, and the battle with his nerves will be half won.

Concussion.—In a mechanised army concussion of varying degrees of severity is a common form of casualty. Diagnosis is usually easy as there is a clear history. A post-concussional syndrome of some sort may result from insufficient hospital treatment. Every case of concussion should be regarded as a stretcher case and evacuated to a base hospital where each case should remain in bed at least fourteen days, and longer when the concussion is severe. Every such patient should be got up gradually. By this long rest the common post-concussional complaints of persistent headache, vertigo, intolerance of sun, etc., will be reduced to a minimum.

"Heatstroke".—A succession of very hot days may produce a number of cases of heat hyperpyrexia. Constipation is a predisposing cause of "heatstroke." The onset may be sudden with a rapid rise of temperature and early unconsciousness. Convulsions can occur when the condition becomes one of extreme urgency. The patient should be stripped, and sprayed with cold water. Fanning can be carried out with a blanket. The idea is to get the patient in a ward with a fan, place him on a rush bed under the fan, and apply ice cold water to body and head. Venesection should be performed if convulsions occur and up to a pint of blood removed. The rectal temperature should be taken every few minutes and hydrotherapy persisted with until the temperature falls to 102° F.

Cerebral Malaria.—Any man found comatose with hyperprexia should be assumed to be a possible case of cerebral malaria, and 10 grains of quinine hydrochloride should be administered intravenously forthwith.

Other mental states resulting from cerebral malaria may resemble acute drunkenness, epilepsy, acute mania, or a delusional state with a tendency to suicide. It has already been said that malaria must never be forgotten in the army, and when there is any doubt it is wiser to give immediate intravenous quinine.

The Prevention of Psychiatric Casualties

What can the medical officer of a unit do to prevent nervous breakdown? The first step is to know officers and men of the unit. This may enable him to weed out less stable individuals before the strain of active warfare finds them out. Thus, the M.O. should suspect men reported as dull, unable to learn drill and to transmit orders, or always in trouble for neglect of equipment and person. Such men are usually backward if not definitely feeble-minded, and are obviously weaklinks in any unit of a fighting army. They should be sent to see a psychiatrist specialist, *with full notes* of their difficulties.

Another group is sometimes found in which there is a history of nervous breakdown in civilian life, and even a period of treatment in mental hospitals. Such men will almost invariably break down under any stress. They often appear in sick parades with vague symptoms. A patient enquiry into the history of the individual often shows earlier lesions of a nervous kind and an unsatisfactory personal and family record.

There are certain character traits and defects pointing to unfitness for military service, in addition to those mentioned. Men are sometimes subjected to continual teasing, ragging or ridicule. They may be bed wetters, inclined to excessive masturbation, given to the senseless destruction of property or cruelty to animals, to outbursts of tearfulness or to suspicion of others. Sleep is often disturbed by restlessness, shouting, or even somnambulism. Criminal tendencies are sometimes exhibited by such men. Persistent petty theft, drunkenness, temper tantrums, over-staying leave, absence from duty, leaving parades without permission, such are the disorders of conduct which point strongly to congenital weakness especially when they are persistent and are uninfluenced by punishment.

In general, it is obvious that any unit requires to be relieved of soldiers who fail to reach the average standard required, and in fighting units cases of the type discussed can be a menace.

Physique.—In the prevention of neurotic casualties a high standard of physical fitness is of great importance. Endurance is in the end dependent upon the standard of physical health maintained, and this is particularly true of warfare under tropical and desert conditions. The medical officer should draw attention to the presence in his unit of men of poor physique. The lower the standard of fitness in a unit, the sooner breaking point is reached under stress, and therefore the higher will be the incidence of neurotic casualties.

Troops should be trained to hardship before service in which endurance to shortage of food, water and sleep may be essential. A warning note must be sounded — it is useless to take men in soft condition, landing from a long sea voyage for

example, and submit them at once to severe training. Cases of effort syndrome in particular have been caused in this way. The medical officer of a unit should be alive to this point and advise the directorate at once if in his opinion men in soft physical condition are being overworked. The very necessary process of hardening must be gradual, but should aim at a high standard. The importance of hygiene cannot be over-estimated. The strictest discipline in hygiene measures is necessary for the maintenance of mental as well as physical health. A certain rivalry or emulation can be developed among combatant officers regarding the perfection of sanitary arrangements in companies, platoons and sections. Medical officers should gain the co-operation of combatant officers on these vital physiological measures. The medical officer should know the officers and men for whose medical care he is responsible, should be accessible to them, and share in their recreations. The sick parade may be regarded as a species of clinical thermometer which will indicate the state of mental health of a unit as well as its physical health. Sudden rises in attendance may well suggest some emotional discontent which it is the duty of the M.O. to unearth and remedy if possible.

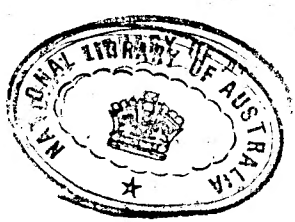
The Disposal of Psychiatric Casualties

Do not use diagnoses like "emotional shock," "shell shock" or "bomb shock." If the case is considered psychotic use the letters N.Y.D.M. If neurotic, use N.Y.D.N.

As much history as possible should accompany all psychiatric cases. A full history is essential when disorders of conduct are in question, as in the psychoses. All psychiatric cases not responding to immediate treatment should be sent to neuro-psychiatric centres which are to be opened.

When a man gives a story of having been "blown up," "dive bombed," "caught in the open by aircraft," "heavily bombed or shelled," every effort should be made to confirm the accuracy of his statements.

By Authority: Arbuckle Waddell Pty. Ltd., 20 McKillop St., Melbourne.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